CLERMONT COUNTY'S MEDICAL PREMIUM DISCOUNT PROGRAM

Annual Physical Discount Voucher —For Covered Employees & Spouses:

Clermont County is offering all benefit eligible employees an opportunity to obtain a discount on their medical payroll deductions in 2016. To qualify, **both you and your spouse (if covered on the plan)** must have an annual physical and routine blood work with your family physician between November 1, 2014 and October 31, 2015 and then submit this voucher, signed by your physician, to Yvonne Smith, Employee Benefits Coordinator before November 6, 2015.

Follow the guideline below to qualify for the 2016 medical plan discount program:

- ☑ Complete your preventative annual physical and routine blood work between November 1, 2014 and October 31, 2015.
- ☑ If your spouse is enrolled in the medical plan, they must also complete a routine physical and blood work within the same time frame in order for you to be eligible any discounts.
- ☑ Have your physician complete and sign the voucher below indicating you or your spouse have completed your routine physical.
- ☑ Return your completed form to Human Resources (Yvonne Smith) **no later than November 6, 2015.**
- ☑ Qualify for the lower medical costs beginning January 1, 2016.

Preventive care is generally less costly than treating illnesses which could have been prevented by routine examinations. **Preventive services and lab work (routine blood tests) are covered at 100% as long as they are coded as preventive and performed by an in-network provider**. Make sure you remind the physician at the time of your visit that it is a preventive visit, if they code it as something other than preventative or if you have additional tests or procedures, your visit and tests may not be covered at 100%.

_____	_____	_____	_____
Print Employee's Name	*Print Spouse Name (if patient is spouse)*	*Patient's Signature*	*Exam Date*

***IMPORTANT NOTE**: Book early!! Physician's offices generally book at least 90 days in advance for routine physicals.*

****Please have your physician complete the information below****

This is to certify that _____ received a routine physical examination and the appropriate preventative blood work was performed.

_____	_____	_____	_____
Date of Service	*Print Name of Health Care Provider*	*Signature of Health Care Provider*	*Practice Type*